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Prolonging Life: A Traditional Interpretation

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The author, director of the Center for Health Care Ethics at St. Louis University Medical Center, says that while writing this article, he benefitted greatly from the assistance and insights offered by Sister Jean Katherine de Blois, C.S.J., Ph.D., St. Louis University Medical School and Rev. Charles Bouchard, O.P., Aquinas Institute of Theology, St. Louis.

In a recent article in this journal,¹ Professor William E. May of the Catholic University of America characterized my interpretation of Catholic Church teaching in regard to withholding and withdrawing life support as "mistaken, mischievous, erroneous, dangerously misleading seriously deficient". While this may not be apt language for debate within the Catholic tradition, the article does provide an occasion to further the search for truth. Seeking to fulfill this search in this article I shall explain briefly the essence of the disagreement, examine some of Professor May's assumptions, and demonstrate that the interpretation I present is in accord with the interpretation of Church teaching offered by recent and ancient authorities in medical ethics.

The Disagreement

Professor May states that the means to prolong life may be judged ordinary or extraordinary (proportionate or disproportionate) insofar as the means to prolong life do or do not impose a grave burden upon the subject or are useful or useless.² While I agree in general with this statement, in accord with the terminology utilized by the Bishops of the United States,³ I prefer to use the term ineffective rather than useless to designate therapy which is extraordinary, that is, which is morally optional. The difference is more than a choice of words. Webster defines useless as "having or being of no use". Ineffective is defined "not producing an intended effect". A therapy may be useful in the sense that it produces an effect but ineffective because the effect produced was not intended. How this distinction applies to our study will be discussed later in this article.⁴ Professor May emphasizes that medical treatment may be judged extraordinary or disproportionate and

hence not morally obligatory only if "objectively discernible features in the treatment itself . . . impose grave burdens on the person being treated or others".⁵ Thus, he would not allow for consideration of the medical (physical) condition of a patient which pre-exists the pathology to be treated. He maintains that only the effects of the therapy may be considered, without reference to the overall condition of the patient before he or she contracted the illness for which therapy is being evaluated. His motive for allowing only "objective features" to be used in the assessment of extraordinary means is expressed as follows: "Too often the judgment that a treatment is useless or excessively burdensome does not reflect serious consideration of the objectively discernible features of the treatment, but an expression of attitudes toward the life being treated".⁶ On the other hand, the conviction of several others as well as myself,⁷ is that the teaching of the Church allows and requires an analysis of subjective factors which pre-exist the treatment, as well as objective factors, before a decision is made to utilize, withhold, or withdraw life support. Hence, I would maintain that subjective factors which pre-exist a fatal pathology and which are not caused by the fatal pathology, may be evaluated when determining whether the therapy to overcome or alleviate the pathology imposes a grave burden or is ineffective. These subjective factors concern the overall condition of the patient, not only the physiological function of the person, but also the social and spiritual functions. To put it another way, the health status of a person which pre-exists a fatal pathology, as well as the person's economic status, may be considered when assessing whether a medical therapy is burdensome or ineffective for a particular person.

The need to consider the subjective and pre-existing factors of the person receiving treatment is evidenced, it seems, by the following statements of Church teaching: "But normally one is held to use only ordinary means — *according to circumstances of person, place, time, and culture* — that is, means which do not involve any grave burden for oneself or another."⁸ How can one consider "the circumstances" without considering the overall condition of the person for whom therapy is contemplated? Another statement of Church teaching maintains: "In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity, or risk, its cost and the possibility of using it and comparing these elements with the result that can be expected, *taking into account the state of the sick person and his or her physical and moral resources*."⁹ How is it possible to consider the "state of the sick person and his or her resources" if one doesn't consider the condition of the person which pre-exists the pathology?

The fittingness of considering the subjective factors which pre-exist the pathology when making ethical decisions concerning life support was also affirmed by the Papal Council *Cor Unum*. When commenting upon the document of the Church, *On Euthanasia*, the Papal Council stated:

The criteria whereby we can distinguish extraordinary measures from ordinary measures are very many. They are applied according to each concrete case. Some

of them are *objective*: such as the nature of the measures proposed, how expensive they are, whether it is just to use them, and what the options of justice are in the matter of using them. Other criteria are *subjective* such as not giving certain patients psychological shocks, anxiety uneasiness and so on. It will always be a question, when deciding upon measures to be taken, of establishing to what extent the means to be used and the end being sought are proportionate.

*Among all the criteria for decision, particular importance must be given to the quality of life to be saved or kept living by the therapy.*¹⁰ (emphasis added)

This latter statement clearly allows for consideration of conditions pre-existing a pathology and the application of means to resist it. While the statement of a Papal Council does not have the same authority as papal teaching, it usually expresses aptly the tradition of the Church. In sum, Church teaching seems to encourage the consideration of subjective factors which pre-exist a fatal pathology when evaluating the moral obligation to use or withhold a particular therapy.

The Purpose of Life

When assessing the ethical imperative to treat a fatal pathology, I assess the grave burden imposed by the therapy, as well as the ineffectiveness. But I consider these as proximate norms for assessing the therapy. Grave burden and ineffective therapy must have a more basic norm for evaluation. Thus, my interpretation of Catholic teaching is based upon the realization that any effort to prolong one's own life or the life of another must be evaluated in regard to the ultimate purpose of human life. Professor May objects to this interpretation.¹¹ Certainly there are many worthwhile proximate goals in life. Health is one of them. But the pursuit of health should be directed to the ultimate goal of life. Prolonging life is not the ultimate nor absolute goal of life.¹² If it were, there would be a moral obligation to prolong human life under all circumstances. If human life were an absolute good, all discussion of proportionate and disproportionate means would be nugatory. In Catholic teaching, the goal of human life is eternal life.¹³ In order to strive for eternal life, we must perform human acts, (acts of intellect and will) under the influence of charity. Acts of man (vegetative and animal acts) of themselves do not bespeak the power to strive for the goal of human life.¹⁴ Hence, if medical therapy will not restore a person to a condition where human acts can be performed by the person, then that therapy would be ineffective or extraordinary. If the therapy would restore or maintain a person to a condition in which the person could strive for the purpose of life only with excess burden, then it is extraordinary from a moral point of view. To see this point more clearly, let us consider the terms "proportionate" and "disproportionate", which have been recommended in place of the terms "ordinary and extraordinary".¹⁵ Something cannot be judged "proportionate" or "disproportionate" unless in relation to a goal. When evaluating, (whether for oneself or for another), whether or not the means to prolong life will be proportionate or disproportionate there must be some goal in mind. Is that goal merely

prolonging human life or is it prolonging life in order to attain eternal life? While prolonging human life more often than not contributes to striving for the purpose of life, there are some situations where this is not verified. When a goal is said to be proportionate or disproportionate then, the goal by which it is evaluated seems to be the ability to strive for eternal life.

Statements from papal teaching seem to confirm the need to refer the moral evaluation of life support to our ultimate goal in life. Pius XII, for example, stated: "Life, health, all temporal activities are in fact subordinated to spiritual ends." The Document on Euthanasia stated: "Everyone has the duty to lead his or her life in accord with God's plan. That life is entrusted to the individual as a good that must bear fruit here on earth, but that finds its full perfection only in eternal life." The Pontifical Council *Cor Unum* is even more specific in regard to the relationship between prolonging life and the purpose of life: "Life is a gift bestowed in order for men and women to accomplish a mission . . . (this mission) involves duty to care for the body, its functions, its organs; . . . to do everything one can to render oneself capable of attaining to God. This duty sometimes requires that we sacrifice health and life; our concern for them cannot allow us to deny the claim of superior values." The term "mission in life" used by the Pontifical Council seems to express quite adequately the idea I have expressed in the words "purpose of life".

When discussing whether means to prolong life are ordinary or extraordinary, usually the discussion centers around the practice of medicine. The need to consider subjective factors pre-existing the onset of disease before recommending therapy is a consistent practice in medicine.¹⁶ While we shall examine explicitly the purpose of medicine later in the article,¹⁷ for now it suffices to realize that physicians always consider the overall condition of their patient before recommending therapy. In clinical situations, simply prolonging the life of a person is not the goal of medicine; persons with advanced Alzheimer's disease are not considered as apt recipients for heart transplants, even if they are otherwise in excellent physical condition. It would be inconsistent for the teaching of the Catholic Church in regard to prolonging life to be at odds with the ethical practice of medicine.

Competent and Incompetent Persons

Insofar as competent patients are concerned, that is, patients who are capable of making their own medical decisions, Professor May seems to have little difficulty allowing for the consideration of subjective or pre-existing factors; that is for factors (whether physiological, intellectual, social, or psychological) which pre-exist the onset of a pathology for which therapy must be evaluated ethically. He affirms: "Competent persons have the right to refuse any "extraordinary" treatment, i.e., any treatment which is useless and burdensome."¹⁸ But in deciding that a treatment is useless or a burden, competent persons consider many subjective and pre-existing

factors. For example, what I decide in regard to suitable therapy will certainly depend upon my overall condition. If I am prolonging life through use of a ventilator, do I want to begin dialysis to overcome kidney failure? What will be my ability to function with and without the proposed treatment? Do I wish to devote my savings to treatment or to the welfare of my family? If the treatment is successful, will a pre-existing financial or nursing burden for my family be prolonged indefinitely?

Professor May's problem with my interpretation seems to concern incompetent patients, that is, those patients who cannot make health care decisions for themselves. Therefore, the remainder of the article will consider decision-making for incompetent patients. Professor May expresses his concern for incompetent patients in the following passage:

What is my problem with O'Rourke's interpretation? . . . I think that O'Rourke errs gravely when he claims that a means is ineffective . . . in helping a person strive for the spiritual purpose of life and that a means is ordinary precisely because it enables a person to strive for the spiritual purpose of life. Why do I think that O'Rourke errs here? Many people, including some seriously handicapped children and some elderly who are not 'with it' persons who are not actually able to judge the truth or falsity of propositions or make free choices, are not capable of striving for the 'spiritual purpose' of life. They cannot do so because in order to do so, a person must be able to make judgments and to make free choices. But those unfortunate human beings are still persons and it is good for them to be alive . . . My problem is that if this (O'Rourke's opinion) is correct, that the lives of countless severely handicapped persons, including infants and the elderly, are regarded as worthless. There are many such persons who are no longer capable or will never be capable of reaching life's spiritual goals . . . But I submit they are still beings of moral worth, i.e., persons whose lives are irreplaceably precious and worthy of our respect and love.¹⁹

Capacity to Perform Human Acts

I have quoted at length from Professor May's article because it demonstrates some erroneous assumptions which confuse the ethical assessment of life support. The first assumption is: That a person who is incapable of making medical decisions is incapable of performing human acts. A human act requires deliberation and choice (intellect and will), but there are various levels of human deliberation and choice and thus various capacities to perform human acts. A person who is incapable of making medical decisions for herself may still make choices about other aspects of her life. An apt analogy arises from the ability to make financial decisions. Simply because a person has a guardian appointed for financial affairs does not imply that the person is incapable of performing human acts, especially in regard to spiritual goods. Making medical decisions usually involves understanding various options for treatment, the cost involved, the alternative to treatment, the possibility of success, and the expected function of the person if the treatment is successful or if the treatment is not utilized. One could be morally and legally incompetent to make medical decisions and still be striving for the purpose of life. By the term "not with it", presumably Professor May refers to people who suffer from dementia

or senility. He seems to imply that dementia or senility are univocal clinical diagnoses. They are not; there are several stages of dementia and senility just as there are several stages of Alzheimer's disease. The most significant clinical symptom of these illnesses is that they are irreversible; they do not deprive a person of the ability to perform human acts at all stages of the illness.

In asserting that people who are senile or who have Alzheimer's disease may still be able to perform human acts, I am not maintaining that they should be kept alive at all costs. As we shall see, senility or Alzheimer's disease may be pre-existing, subjective factors which are factored into the decision concerning treatment for a fatal pathology and whether the means to treat the pathology are proportionate or disproportionate. But to assert that the interpretation of Church teaching which allows for consideration of pre-existing subjective factors leads to neglect and death for seriously handicapped children and elderly people is an extrapolation with no basis in clinical medicine nor in ethical reasoning.

There is one clinical condition however, which is incompatible with human acts. People in a medically diagnosed persistent vegetative state (PVS) suffer from a dysfunctional cerebral cortex and thus are unable to perform the bodily acts which dispose for acts of the intellect and will, that is, acts of cognitive affective function.²⁰ In recent years, especially when commenting upon the Paul Brophy and Nancy Beth Cruzan cases, I have stated that because persons in PVS are unable to perform human acts, there is no moral obligation to keep them alive. While they are still persons, they do not benefit from life support.²¹ Moreover, patients in PVS have a fatal pathology. Because their cerebral cortex is dysfunctional, they are unable to perform the conscious acts of chewing and swallowing.²² The pathology which hinders chewing and swallowing can be circumvented by artificial hydration and nutrition. But if the pathology is circumvented by artificial hydration and nutrition, the person will not regain the ability to perform human acts which are necessary in order to strive for the purpose of life. Just as a person with a dysfunctional cerebral cortex cannot perform the conscious actions necessary to strive for the purpose of life, so they cannot feel pain.²³ There is no moral obligation to prolong the lives of people in this condition through care or through therapy. Hence there is no obligation to circumvent the pathology affecting their ability to chew and swallow. Allowing the pathology to take its natural course does not bring on "starvation and dehydration." Some people, especially when writing Letters to the Editor, declare that Nancy Beth Cruzan was "starved to death." This language brings to mind the vision of a conscious and competent patient being deprived of nourishment which would benefit her. But people in a persistent vegetative state can no longer feel pain, can no longer chew or swallow, and can no longer strive for the purpose of life. Moreover, when a respirator or artificial hydration and nutrition are removed from a patient who will not benefit from such therapy the intention of the agent is the desire to stop ineffective therapy; not to kill the patient. The cause of death

is the underlying pathology.

Professor May and several co-authors believe that medical therapy is not burdensome or ineffective if it merely prolongs physiological function of persons in PVS and does nothing to restore their social and spiritual functions. They maintain that life in this condition is a "great benefit."²⁴ Most medical professionals and "lay people" do not seem to agree. Over the past five years, I have asked thousands of people: "If you were in a persistent vegetative state, would you want your life prolonged by means of artificial hydration and nutrition," No one has ever said "yes." While this overwhelming reaction may not be a theological proof, it is an insight that cannot be ignored. Moreover, it makes us question if life in this condition is a "great benefit".

Finally, the clinical practice of medicine supports the ethical reasoning which allows for removal of life support from patients who will not recover cognitive-affective function. Few physicians would state that it is their responsibility to prolong physiological function if it does not enable the patient to function at the cognitive-affective level. If physicians treat people in a comatose condition, it is with the hope of restoring some degree of cognitive-effective function.²⁵ That medicine has more in mind than mere physiological function is affirmed by contemporary authorities in the field. Leon Kass describes the purpose of medicine in this way: "Healing is thus the central care of medicine: to heal the whole is the doctor's primary business . . . that wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire, move, and maintain itself . . ." ²⁶

Pellegrino and Thomasma offer the following definition of medicine: "We have defined the end goal of medicine as a right and good healing action for a particular patient . . . The aim of medicine is to address not only the bodily assault that disease or an injury inflicts but also the psychological, social, even spiritual dimensions of this assault. To health is to make whole or sound, to help a person reconvene the powers of self and return, as far as possible to his conception of a normal life."²⁷

Quality of Life

The second assumption underlying Professor May's opinion is that removing life support should not be based upon "quality of life" decisions.²⁸ Others seeking to apply the Catholic tradition to cases concerning the removal of life support maintain this position even more strongly.²⁹ The main difficulty in regard to this assumption is that Professor May and others use the term quality of life as though it were a univocal term having only one meaning. This leads Professor May to confuse the norms for care of disabled people with care of those who will not benefit from therapy. Actually, quality of life is an analogous term and has at least three different meanings.³⁰ All three meanings of the term imply that a person suffers from impaired human function. But the circumstances of the persons with

impaired functions differ considerably. In one sense of the term persons with genetic or acquired disabilities are said to have a "diminished quality of life" because they cannot perform actions in a "normal" manner. Even though these persons have physical or mental disabilities they are not necessarily suffering from a fatal pathology. The term quality of life is also used to refer to people who have impaired function precisely because they are suffering from a fatal pathology. Thus, someone with cancer of the brain would not function in a normal manner, and would have a diminished quality of life, precisely because of the pathology from which he or she suffers. Thirdly, quality of life is used when referring to people who have less than normal function, who also have a fatal pathology, but whose impaired function is not the result of the fatal pathology. Thus, an infant with Down Syndrome (impaired function), may also suffer from duodenal atresia (fatal pathology).

The decision to withhold or withdraw life support differs for people in the three different categories. Concerning persons in the first category; that is, those who are impaired but have no fatal pathology, there is no ethical or medical basis for making a decision to withhold the care which enables them to continue living. The decision to withhold or withdraw life support is only made when a fatal pathology is present. To withhold life support from people without a fatal pathology would be the same as intending their death. Intending (causing in the proper sense of the term) the death of another is always contrary to Catholic teaching.³¹ Thus, when a disabled person has sufficient homeostasis to support life, that person is not a candidate for decisions concerning ordinary and extraordinary means to prolong life. History recounts that in some societies the cause of death was induced in persons with a low quality of life. Clearly, putting persons to death simply because they had impaired function was a heinous crime. Even if defended on the grounds that it eliminated the suffering of people with "diminished quality of life," it constituted euthanasia. But it is irresponsible to equate every act of withholding life support from people with impaired function with euthanasia, whether active or passive. And it is equally irresponsible to suggest that removing life support from people with a diminished quality of life (i.e., impaired function) who suffer from a fatal pathology always implies the intention of causing their death. In the face of impaired function and fatal pathology, people often experience the limits of medicine and remove life support because they intend to remove a burden from the patient or realize their efforts to help the patient are no longer beneficial.

For people in the second and third categories, quality of life must often be considered when ethically assessing the use of life prolonging therapy. For example, Mom has a brain tumor. Because of the tumor, her cognitive and affective functions are severely impaired. She fits into the second category of people with a diminished quality of life. Her impaired cognitive-affective function is the direct result of her illness. Mom's kidneys start to fail. Clearly, Mom's life could be prolonged for at least a few months through

dialysis. But would the added time of life enable Mom to better fulfill her mission in life? It seems that Mom's pre-existing subjective condition (impaired cognitive-affective function) would justify ethically the decision to forego renal dialysis and thus allowing Mom to die of end stage renal failure. Even though we would foresee Mom's death, we would not intend Mom's death. Rather, we would be admitting our limits to help her strive for the spiritual purpose of life in the face of fatal pathology.

People in the third category, that is, those who have impaired function and a fatal pathology, but whose impaired function is not the result of the fatal pathology, offer the most difficult ethical decisions. In these cases, we must attempt to discern whether circumventing or alleviating the pathology will enable them to strive for the spiritual purpose of life. Many infants born with genetic anomalies are in this category. For example, an infant suffers from severe neurological impairment and also has impaired pulmonary function. The pulmonary pathology could be circumvented. It is necessary to circumvent the pulmonary pathology by means of a respirator and thus prolong the infant's life. Applying the ethical norms of "grave burden" and "ineffective" therapy to infants with a diminished quality of life is more difficult than applying it to other persons. The prognosis for infants is always tinged with uncertainty and that makes decisions of this nature more difficult. Every neonatal care physician or nurse can cite a case when an infant survived and thrived, contrary to professional expectations. Moreover, when judging the future well-being of a disabled infant, we must not underestimate the value of human life. Adults born with genetic or acquired anomalies are vociferous in appealing for life support for debilitated infants.

Clearly, unethical decisions have been made in regard to infants who have a diminished quality of life and a fatal pathology. The Baby Doe case in Indiana is a good example.³² Baby Doe was a child born with Down Syndrome and duodenal atresia. Unless simple surgery were performed to correct the atresia, he would be unable to digest food and would thus die in a few days. Because Baby Doe had a diminished quality of life, he was allowed to die from the duodenal atresia. Would the therapy have been burdensome? No; it is performed routinely on normal infants. Would this therapy have been effective, that is, would the therapy have allowed Baby Doe to strive for the purpose of life? Yes, indeed; retarded children are able to perform human acts and do strive for a spiritual purpose in life. Even though Baby Doe died because of a pathology present in his body, not because of an induced pathology, there was no ethical ground for withholding surgery. Thus, he was a victim of passive euthanasia.

From the foregoing discussion of "quality of life", two observations emerge:

- 1) Quality of life is an analogous term; it is used to refer to people in many different conditions. The term should not be used as a weapon, as it often is, to imply that every decision to withhold and remove life support is an act of active or passive euthanasia.

2) As the Papal Council *Cor Unum* and other authorities indicate,³³ the term quality of life is an acceptable term when referring to subjective factors which will influence decisions concerning life support. But because of the emotional response to the term, rather than use the term "quality of life" when discussing ethical decisions concerning withholding or withdrawing life support, the term *quality of function* seems more fitting because it is less inflammatory and more descriptive.³⁴ Assessing the quality of function in relation to striving for the purpose of life becomes important when making an ethical analysis concerning life support.

Imminent Death

A third assumption underlying Professor May's thinking is the conviction that life support may never be removed from incompetent patients unless death is imminent; and death is never considered imminent if human life can be prolonged through life support. Thus, unless the life support fails, or functions improperly, so that it imposes a grave physiological burden upon the patient, the life support may not be removed from incompetent patients. To put it another way, Professor May would hold that life support must be utilized as long as it will prolong life for an incompetent person. The cognitive-affective function of the person is irrelevant if life can be prolonged. Professor May does not refer explicitly to this assumption in his recent article, but it serves as a basis for his thought in another article co-authored with a spectrum of theologians.³⁵ Often the same thought is expressed in the words: "The patient is not dying, therefore life support cannot be removed." However, Catholic tradition has never limited the removal of life support to situations in which the patient is dying. Rather, Catholic tradition allows the questions of burden and effectiveness to be asked when a fatal pathology is present, whether death is imminent or not.³⁶

The assumption that life support may be removed only if death is imminent seems to be derived from a popular legal interpretation of the term "terminal illness". The interpretation in question results principally from laws and prevalent court decisions but people in non-legal professions often accept the interpretation. In the Cruzan case for example, the Missouri Supreme Court offered as one argument for continuing artificial hydration and nutrition for Nancy Beth Cruzan, the statement "that Nancy was not in a terminal condition," meaning, that she would not die in the foreseeable future because the life support circumventing her fatal pathology would continue to prolong her life.³⁷ The Missouri Court used the legal definition of terminal illness usually contained in its Living Will Legislation. Thus terminal illness was considered an illness which would lead to death in the immediate future *even if* life support had been applied. According to this interpretation, if life support has been applied and is successful, the patient's death is no longer imminent. Thus the illness in question is not considered a terminal illness. This mode of thinking leads

some physicians, often fearing legal liability, to continue life support long after it is beneficial for the overall well-being of the patient. It also leads several anti-euthanasia activists to protest the death of any person, no matter what the quality of function, who could be kept alive.

The Supreme Court of Illinois has recently clarified this misunderstanding by redefining the meaning of "terminal illness" at least insofar as the State of Illinois is concerned. In the Greenspan case (1990), the Court pointed out that the usual legal interpretation of terminal illness leads to a vicious circle, renders living wills meaningless and makes it impossible for compassionate care for people unable to benefit from therapy. The Court declared: "If the very delay caused by the procedures were allowed to govern the assessment of imminence, the (Living Will) Act's definition of a terminal illness would be rendered circular and meaningless. *Imminence must be judged as if the death delaying procedures were absent.* The implication of this statement is found in the Court's statement: "With feeding tubes, patients have been known to live for years in a chronic vegetative state; *such a fact is irrelevant.*"³⁸ (emphasis added)

This interpretation of terminal illness and imminent death which calls for an evaluation of the illness "as if the death delaying procedures were absent", is more in accord with the teaching of the Church. In Catholic teaching, the "imminence" of death is not *per se* a requisite for the ethical decision to remove life support. A person could refuse surgery to remove a serious cancer, and still live a long time after the cancer has been diagnosed. Surely, the imminence of death may be utilized as one of the factors in determining whether therapy is an excessive burden or ineffective; that is, whether therapy will affect one's ability to strive for the purpose of life. However, the ethical decision to withhold or withdraw life support might be made even if death is not imminent.³⁹ In the Catholic tradition, removal of life support does not hinge upon a determination that a person is dying or that death is imminent. Rather, the central issue in this tradition is whether or not the therapy needed to overcome or alleviate the fatal pathology will impose a grave burden or will be ineffective, subjective and pre-existing factors being considered. Or to put it another way: Will prolonging life benefit the patient insofar as the spiritual purpose of life is concerned?

The conviction that life must be prolonged at all costs, and that the only way we can show our respect for human life and our love for others is to prolong life, no matter how impaired their capacity to function, seems a bit out of place when compared to Catholic teaching in regard to death and resurrection. One contemporary author maintains the emphasis upon keeping people alive at all costs is a sign of the secularization of Catholicism in the United States.⁴⁰ According to Catholic faith, death is not the end of existence and our life on earth is the beginning of eternal life. As Rahner put it: "Man cannot understand his present in any other way except as the beginning and the coming to be of a future and in the dynamism toward it. Man understands his present only insofar as he understands it as the approach toward and the opening up of a future."⁴¹ Suffering and death,

which no one can avoid in this life are realities which can be transformed into the fullness of human life. Hence, allowing a person to die when continued therapy is no longer beneficial is not abandonment, nor does it bespeak a lack of respect and love, which Professor May seems to suggest. Our efforts as Christians, it seems, should be directed toward accepting death and demonstrating our hope in God's gift of eternal life; not by trying to force every last second out of human life. The emphasis upon prolonging life at all costs seems to consider the "good" of human life as something apart from the person who is living it. Professor May's insistence that "life is never a burden" seems also to separate the "good of human life" from the way people experience their lives. When he says "life is never a burden", he wishes to prove that suicide and euthanasia are never justified. This is accepted Catholic teaching. But the basis for this teaching is the nature of a person's relationship to God the Creator, not the thought that "life is never a burden" or that "life is a good of and for the person."⁴²

Authors in Agreement

The opinion which directs analysis of medical means to the spiritual purpose of life and which maintains that the pre-existing, subjective conditions affecting the function of the patient may be considered when determining whether or not life support should be utilized is not innovative or radical, as Professor May implies. For example, Gerald Kelly, writing in 1958, declared: "As I said many physicians believe that a more moderate standard may be followed . . . They try to preserve life as long as the patient himself can reap any tangible benefits from the prolongation. But they also think there is a point when such efforts become futile gestures . . . The moderate standard . . . seems to be very much in accord with the traditional policy of Catholic theologians of interpreting obligations according to a reasonable limit . . . Finally, it seems evident that the moderate standard is less likely to impose the excessive burdens on the patient's relatives. Relatives often endure terrific strains and undergo great expense while life is being prolonged by artificial means, and in some cases, the terminal coma; little good seems to be accomplished."⁴³

Thomas O'Donnell, S.J. in 1976 stated that commonly available techniques of modern surgery and medicine should usually be utilized. But he adds: "These techniques need not be utilized in some circumstances. The relation of their use to the remaining potentiality of what we have called the 'fundamental context of human life' should be the basis of the moral judgment as to whether such modern means must be used or not."⁴⁴ O'Donnell's "fundamental context of human life" is similar to the spiritual purpose of life.⁴⁵

Finally, Francis deVittoria, writing in the 16th century, describes a pre-existing psychological condition which determines whether or not a person must use food to avoid death. He stated: "If a sick man can take food with a certain hope of life, he is held to take the food. But if his spirits are

depressed and his appetitive powers are so disturbed that eating food becomes a torture, it would be considered an impossibility for the man to take food. Hence, he would be excused, at least from mortal sin, especially where there is little hope of prolonging life.⁴⁶

Conclusion

Certainly, one may follow the opinion that life must be prolonged as long as possible, apply the terms "grave burden" and "useless" without referring them to the spiritual goal of life, and demand that life support never be removed unless the patient is "terminal" and still be within the Catholic tradition. But a more extensive interpretation of Catholic teaching is also consistent with the Catholic tradition and does not seem to be "erroneous, mischievous, dangerously mistaken, nor seriously deficient." Rather it seems to be in accord with the Church teaching, and is traditional in the sense that it has been accepted through the years in clinical situations by families, physicians and theologians. It seems, therefore, an acceptable and workable interpretation of the Catholic tradition would:

1) consider the pre-existing subjective conditions of the person when discerning whether therapy to overcome or alleviate a fatal pathology imposes a grave burden or is ineffective;

2) use the spiritual purpose of life to assess grave burden and ineffective therapy;

3) allow the withdrawal of life support even if life could be prolonged, provided there is a grave burden which would impede pursuing one's mission in life or provided the therapy is ineffective insofar as helping a person strive for the spiritual purpose of life.

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2. *Op cit.* p. 82; John Connery, states that: "Originally, the distinction between ordinary and extraordinary means to prolong life was based only on grave burden, experienced before, during or after the treatment." Medical means which were useless were not considered mandatory because of the general realization that useless actions are not required morally. (*Summa Theologicae*, II-II, Q.6 a.3) But useless means were not called extraordinary. "Today, most theologians subsume the distinction between useful/useless means under the definition of ordinary/extraordinary means. Connery warns combining the two terms can cause confusion. "Prolonging life: The Duty and its Limits," *Catholic Mind*, October 1980, p. 42.
3. "Every patient should be provided with measures which can effectively preserve life without involving too grave a burden." National Conference of Catholic Bishops, "The Rights of the Terminally Ill," *Origins*, 16:12, pp. 222-224.
4. p. 12; p. 16 of this text;
5. *Op. cit.*, p. 88.
6. *Op. cit.*, p. 82.
7. McCormick, Richard, "To Save or Let Die, The Dilemma of Modern Medicine," *Journal of the American Medical Association* 229 (1974) pp. 172-176. Thomas Schindler, "Implications of Prolonging Life," *Health Progress* (April, 1988), 12. Dennis Brodeur,

"Bishops' Response to Act on Rights of Terminally Ill," *Health Progress*, (January, 1987), p. 22ff. Cf. also authors cited in footnotes 36, 37, 38.

8. Pius, XII, Pope, "The Prolongation of Life," (Nov. 24, 1957) *The Pope Speaks* 4:4 (1958), p. 395.

9. Congregation of the Faith, "Declaration on Euthanasia," (May 5, 1980) *Origins* 10:10, p. 154.

10. Pontifical Council *Cor Unum*, "Questions of Ethics Regarding the Fatally Ill and the Dying", Vatican Press, 1981.

11. *Op. cit.*, p. 86; On the other hand, Gerald Kelly, S.J. used the "spiritual benefit" resulting from therapy as a consistent norm in his writings. "The Duty Using Artificial Means of Preserving Life," *Theological Studies* (June, 1950), p. 219.

12. "Declaration on Euthanasia".

13. *Ibid.*

14. *Summa Theologicae* I-II, Q1, ;a.1.

15. "Declaration on Euthanasia".

16. Pellegrino, Edmund & David Thomasma, *For the Patient's Good, The Restoration of Beneficence in Health Care*, New York: Oxford University Press, 1988, pp. 80-83; 170-171.

17. Cf. page 13 of this text.

18. *Op. cit.*, p. 82.

19. *Op. cit.*, p. 86.

20. The intellect and will are faculties of the soul. But in the human condition, soul and body are so united (an *unum per se*) that the soul needs a functioning body in order to actualize the intellect and will. The part of the body which must function in order for the soul/body entity to perform human acts is the cerebral cortex. (Cf. *Summa Theologicae*, I, q. 75, a. 2; I, a. 84, a. 6, 7).

21. Boyle, Philip, Larry King, M.D. and Kevin O'Rourke, "The Brophy Case: The Use of Artificial Hydration and Nutrition," *Linacre Quarterly*, May, 1987, 54:2, pp. 63-71.

Kevin O'Rourke, "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons," *Issues in Law and Medicine*, 5:2, (1989) pp. 183-196.

22. "Position of the American Academy of Neurology on Certain Aspects of Persistent Vegetative State Patients," *Neurology* 39:125 (1989) p. 126.

23. *Op. cit.*, *Neurology*, 1989. Allowing anencephalic infants to die, without life support, has long been considered an ethical practice. Their condition is similar to patients in PVS.

24. William E. May, *et al.*, "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable People," *Issues in Law and Medicine* 3:3 (1987) p. 209.

25. *Op. cit.*, *Neurology*, 1989; Cf. L. H. Schneiderman, N.S. Jecker, A. R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, 112:12 (June 15, 1990) pp. 949-953. "In keeping with the qualitative notion of futility, we propose that any treatment that merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care should be regarded as non-beneficial and therefore futile." (p. 952)

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31. *On Euthanasia, op. cit.*

32. "Court Upholds Parents' Wish to Let Retarded Newborn Die," *Chicago Tribune*, (Friday, April 16, 1982).
33. Cf. Connery, *op. cit.*, p. 51.
 Germain Grisez, "A Christian Ethics of Limiting Medical Treatment," *Bioethical Issues*, Pope John Paul Bioethics Center, Cromwell, Ct. (1986) p. 42; "In this sense, quality of life considerations are unavoidable elements."
34. O'Donnell, T. J., unpublished paper on May *et al*, Cf. footnote #22.
35. *Op. cit.* May, *et al*.
36. Cf. Connery, *op. cit.*, p. 47. "Use of the distinction between ordinary and extraordinary means was not limited to terminal cases."
37. Supreme Court of Missouri, Nancy Beth Cruzan, by Co-guardians, Lester L. Cruzan, Jr. and Joyce Cruzan v. Robert Harmon, No. 70813, (Nov. 16, 1988) *Petition of Certiorari in the Supreme Court of the United States*, October Term, 1988, p. A9; A26.
38. Illinois Supreme Court, "In Re: Estate of Sidney Greenspan v. Andrew Gelman, Guardian *ad litem*, Docket N. 67903 (July 19, 1990) p. 15.
39. Connery, *op. cit.*, p. 47 and Pontifical Council *Cor Unum*, *op. cit.*
40. Bole, III, Thomas, "The Ordinary-Extraordinary Distinction Reconsidered: A Moral Context for the Proper Calculus of Benefits, and Burdens," *Hospital Ethics Committee Forum*, 2:4 (1990) p. 226.
41. Rahner, Karl, *Foundations of Christian Faith*, (New York: Crossroads, 1978), on eschatology, p. 434.
42. *Op. cit.*, p. 89.
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